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### **Curiosity and the CAT: Considering Cognitive Analytic Therapy as an intervention for psychosis**

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### **Abstract**

In the interests of providing patient choice and developing more effective interventions for people struggling with psychosis it is important that alternative talking therapies are explored. Cognitive Analytic Therapy is an integrative therapy which has specific features that that may be particularly suited to psychosis. The current report briefly outlines this approach and its potential benefits.

**Keyword:** Cognitive Analytic Therapy; Psychosis; Intervention

## **Curiosity and the CAT: Considering Cognitive Analytic Therapy as an Intervention for Psychosis**

There is a growing use of “talking therapies” in treating psychotic disorders. Cognitive Behavioural Therapy (CBT) is arguably the most widely studied talking therapy for treating psychosis, and is recommended for use in UK guidelines (National Institute for Health and Care Excellence, 2014). However, CBT does not work for everyone and effect sizes are typically small to moderate (Sarin, Wallin & Widerlov, 2011; Wykes, Steel, Everitt & Tarrier, 2008). Moreover, different psychosocial interventions for psychosis may impact upon different outcomes (Turner, van der Gaag, Karyotaki & Cuijpers, 2014). The importance of patient choice within the UK has also been emphasised (Department of Health, 2012). With these issues in mind it is vital that we remain curious about alternative therapies for those with experiences of psychosis.

Cognitive Analytic Therapy (CAT; Ryle & Kerr, 2002) represents an alternative talking therapy. CAT is an integrative therapy, which draws upon many of the principles of cognitive therapy, but combines these with ideas from personal construct, object relations and social developmental theory. CAT involves a process of mapping out historical interpersonal experiences and identifying enactments of similar relationship patterns in a person’s day-to-day life. A theoretical CAT model of psychosis has been developed and illustrated in individual case studies (Kerr et al., 2003; Kerr, Crowley & Beard, 2006; Perry, 2012). This model provides an account of how certain ways of relating to self and others ( ‘Reciprocal Roles’ [RRs]) develop over time and are enacted in day-to-day life. The formation of these RRs is largely socially mediated. Within this model, psychotic experiences can be understood as representing disordered or extreme expressions of RRs (Kerr, Birkett & Chanen, 2003). For example, paranoia may represent an underlying RR of ‘victimised and targeted’ in relation to an ‘abusive and threatening’ other (possibly a product of early abuse or hostile

parenting). A malicious voice may result from early experiences of a critical other that is first *internalised* as a RR and then *externalised* (or dissociated) as a voice perhaps because it was too painful (Perry, 2012). CAT is a *fundamentally* interpersonal model, adopting a dialogical perspective of the self (i.e., that the self emerges and develops through the ongoing interaction with others) that emphasises social, cultural and interpersonal influences, and so differs to interpersonal varieties of CBT (Ryle & Kerr, 2002).

CAT has a number of strengths for working with experiences of psychosis: 1) The emphasis in CAT upon interpersonal relationships is relevant as many of the difficulties that are considered indicative of psychosis are both inter and intrapersonal in nature (e.g., paranoia, voices; Berry, Wearden, Barrowclough & Liversidge, 2006). 2) The dialogical component (making links between ‘self-self’ and ‘self-other’ relationships) may be particularly useful in explaining some of the processes by which ‘normal’ everyday experiences, as well as more traumatic experiences, can lead to seemingly bizarre experiences. CAT-specific tools such as the reformulation letter provide a means of mapping out these links between early experiences and difficulties. 3) Viewing psychosis in terms of early interactions is consistent with the link between interpersonal trauma and psychosis (Read, van Os, Morrison & Ross, 2005). 4) CAT provides a coherent framework working with ruptures in therapy and difficulties around engagement. 5) The dialogical nature of CAT provides a means of representing stigma (fundamentally a social process), where present, as a central part of the phenomenology of the psychosis, rather than a secondary difficulty.

A Recent review suggests support for the efficacy of CAT in a variety of disorders, most often complex presentations (e.g., personality disorder; Calvert & Kellett, in press). Positive findings have emerged within a recent trial of CAT for bipolar disorder (Evans & Kellett, 2014). However, research into CAT for those with psychosis is still in its early phases. Initial evidence of the safety and acceptability of CAT for individuals with

experiences of psychosis exists from case-studies and small case-series (Graham, 1995; Kerr et al., 2001), and trials of multi-modal interventions (Gleeson et al., 2012). Based on the Medical Research Council's guidance concerning the evaluation of complex interventions, we believe the next step is to further confirm the safety and acceptability of CAT through a larger case-series of CAT for individuals with psychosis (Craig et al., 2012).

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